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Accelerating progress towards the Millennium Development Goals: options for sustained and inclusive growth and issues for advancing the United Nations development agenda beyond 2015

Annual report of the Secretary-General

Summary

The present report summarizes recent progress made towards the achievement of the Millennium Development Goals and contains recommendations aimed at advancing the development agenda beyond 2015. At the request of Member States, it explores issues relevant to the fostering of sustained and inclusive economic growth as part of strategies to achieve the Goals, with a particular focus on employment creation. It concludes that much greater coherence is needed among macroeconomic, trade, investment, financial, rural development and social policies in order to promote sustained and stable economic growth and the adequate creation of decent work, while ensuring environmental sustainability. Coherent national policy efforts will need to be supported by reinvigorating the global partnership for development. This could be done by restoring cuts in aid budgets and meeting all aid commitments, enhancing market access for developing countries, making additional efforts to ensure external debt sustainability, and carrying out further initiatives to provide affordable access to essential medicines and new technologies. The report recommends that urgent attention be focused on ensuring coherence between the follow-up to the United Nations Conference on Sustainable Development and the preparations for the post-2015 United Nations development agenda.

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I. Introduction

1. In the outcome document of the High-level Plenary Meeting of the General Assembly on the Millennium Development Goals, Member States requested the Secretary-General to report annually on progress in the implementation of the Goals and to make recommendations for further steps to advance the United Nations development agenda beyond 2015.[1] Subsequently, its resolution 65/10, the Assembly requested the Secretary-General to include in his annual report an analysis of and policy recommendations on sustained, inclusive and equitable economic growth for accelerating poverty eradication and achievement of the Goals.

2. The present annual report is the second prepared in response to those requests.[2] This year, in covering progress made in achieving the Millennium Development Goals, the report is focused in particular on the global employment challenges faced by many countries and on delivering on the global partnership for development. The final section includes further recommendations aimed at advancing the United Nations development agenda beyond 2015.

II. Progress in achieving the Millennium Development Goals[3]

A. Progress achieved

3. Significant progress has been made in terms of achieving the Millennium Development Goals. A number of important targets have been met:

(a) The global target of reducing extreme poverty in half was met five years ahead of the 2015 deadline. This achievement was greatly helped by accelerated poverty reduction in populous China and India;

(b) The target of halving the proportion of people without reliable access to improved sources of drinking water has already been met;

(c) Conditions for more than 200 million people living in slums have been ameliorated, exceeding by twofold the admittedly modest 2020 target;

(d) On average across the world, gender equality in terms of access to primary education has been achieved, as school enrolment rates for girls are now at par with those for boys.

4. Further progress has also been made towards other Millennium Development Goal targets, such as reducing child and maternal mortality, but the world community still has a long way to go to achieve all the targets by 2015.[4] Significant additional national and international efforts and the fulfilment of the commitments

[1] See General Assembly resolution 65/1, para. 81.

[2] The first report (A/66/126) was submitted to the General Assembly at its sixty-sixth session, in September 2011.

[3] Unless otherwise noted, this section draws from the information base developed for the *Millennium Development Goals Report 2012*, Department of Economic and Social Affairs (New York, 2012).

[4] The present report takes into account examples of good practices in accelerating progress towards the achievement of the Millennium Development Goals, including those employed by civil society organizations active at the national level.

made with a view to developing a global partnership for development (Goal 8) will be critical.

5. Driven by national and international efforts and inspired by the Millennium Development Goals agenda, many more of the world's children are now enrolled in school at the primary level. Access has improved significantly since 2000. Girls have benefited the most. The ratio between the enrolment of girls and that of boys increased from 0.91 in 1999 to 0.97 in 2010 for all developing regions, falling within the plus-or-minus 3-point margin of 100 per cent, which is the accepted measure for parity. For least developed countries it increased even faster during the same period, from 0.84 to 0.94. Similarly, net primary school enrolment rates increased markedly in sub-Saharan Africa, from 58 per cent to 76 per cent, during the same period. These are significant achievements given the fast growth of the population in primary-school-age population in the poorest countries.

6. Millions of lives has been saved thanks to improvements in child and maternal health care, the expansion of HIV treatment and targeted interventions to control and treat malaria. Child survival has gained further momentum. In sub-Saharan Africa — the region with the highest level of under-5 mortality — the pace of the reduction in child deaths doubled from 1.2 per cent per year during the 1990s to 2.4 per cent during the 2000s. Overall, under-5 mortality declined by 35 per cent between 1990 and 2010, from 97 to 63 deaths per 1,000 live births. The number of deaths from measles was reduced by 74 per cent from an estimated 535,300 in 2000 to 139,300 in 2010.

7. Fewer people are becoming infected with HIV, although the decline in new infections varies across regions and countries. Globally, new infections were down 22 per cent in 2010 compared with 2001, with paediatric infections dropping 43 per cent from their peak in 2002. Despite progress for the world population at large, the number of new HIV infections has increased in Eastern Europe, Central Asia and the Middle East, driven largely by the increased use of injection drugs. In nearly all countries in sub-Saharan Africa, women, especially those between the ages of 15 and 24, are at higher risk of living with HIV. The most recent prevalence data indicate that sub-Saharan women are 30 per cent more likely to be infected with HIV than men.[5] Increased availability of HIV treatment explains much of the progress made in containing the disease. By the end of 2011, an estimated 8 million people had gained access to HIV treatment, and 10 countries, several of which are located in the high-burden region of sub-Saharan Africa, had reached the target of universal access to antiretroviral treatment.[6] In contrast, fewer than 20 per cent of those infected had received antiretroviral treatment in low- and middle-income countries of Europe and Central Asia.[7]

8. The estimated incidence of malaria has decreased globally by 17 per cent since 2000, with malaria-specific mortality rates decreasing by 25 per cent. The world is also on track to meet the target of halting and beginning to reverse the spread of tuberculosis, with incidence rates having fallen since 2002. Between 1995 and 2010,

[5] See *UNAIDS Report on the Global AIDS Epidemic 2010*, Joint United Nations Programme on HIV/AIDS (UNAIDS) (Geneva, 2010).

[6] Universal access is reached when access to antiretroviral treatment reaches or exceeds 80 per cent of need.

[7] See *Towards Universal Access: Scaling up priority HIV/AIDS Interventions in the Health Sector: Progress Report 2010*, World Health Organization, UNAIDS, UNICEF (Geneva, 2010).

an estimated 7 million lives were saved through the successful treatment of tuberculosis.

9. The world has met the Millennium Development Goal drinking water target five years ahead of schedule. In 2010, 89 per cent of the world's population had access to improved drinking water sources, reflecting an increase of 13 per cent compared with 1990 levels. If recent trends continue, 92 per cent of the world population will have gained access to improved sources of drinking water by 2015, well above the internationally agreed target.

B. Shortfalls in the achievement of the Millennium Development Goals

10. The achievement of the Millennium Development Goals has been uneven across and within regions and countries, however. Most often, it is the poorest and those most marginalized and discriminated against on the basis of, inter alia, gender, age, disability and ethnicity who have seen the least progress. Moreover, progress has slowed in some areas, and a few of the goals remain out of reach.

11. Hunger and undernutrition remain the most critical of global challenges. The Food and Agriculture Organization of the United Nations (FAO) estimates that 925 million people were living in hunge in 2010.[8] This contrasts with the reduction achieved in income poverty. Even though the impact of the 2007-2008 food price crisis was not as detrimental as previously assumed, the prevalence of hunger remains high, especially in sub-Saharan Africa and South Asia (excluding India). The vulnerability of food systems to droughts and floods, together with land degradation, further aggra ates food security, especially in poor countries. In addition, large disparities between rural and urban areas persist.

12. Progress has also been slow in reducing undernourishment among children. Recent estimates show that children in the lowest-income households are almost three times as likely to be underweight as children in the wealthiest 20 per cent of households in developing countries. Furthermore, children living in rural areas are almost twice as likely to be underweight as children in urban households in the developing world. Undernutrition is a cause of stunting, which can lead to diminished cognitive and physical development. Studies have shown that public programmes targeted to the poor, greater gender equality and improved rural infrastructure are critical to better nutrition-related outcomes.[9] Hence, nutrition must be placed higher on the national development agenda to uproot the leading causes of persistent undernourishment in developing and least developed countries.

13. Despite the fact that some progress has been made towards greater gender equality (Millennium Development Goal 3), women remain in a disadvantaged position in many fields, especially in terms of access to productive employment opportunities in the formal sector, productive resources, sexual and reproductive

[8] See *The State of Food Security in the World 2011: How Does International Price Volatility Affect Domestic Economies and Food Security?*, FAO, International Fund for Agricultural Development, World Food Programme (Rome, 2011).

[9] See *Accelerating Equitable Achievement of the MDGs: Closing Gaps in Health and Nutrition Outcomes: Asia-Pacific Regional MDG Report 2011/12*, Economic and Social Commission for Asia and the Pacific, Asian Development Bank, United Nations Development Programme (Bangkok, 2012).

health care and political decision-making. More than half of the world's women are in vulnerable employment, and only one in five parliamentarians worldwide is a woman.[10] In most developing countries, gender disparities also persist in access to secondary and tertiary education. The scourge of violence against women and girls, including conflict-related sexual violence, holds back progress on the achievement of all the Goals.

14. Although the number of maternal deaths declined by 47 per cent between 1990 and 2010 to an estimated 287,000 deaths worldwide, and the maternal mortality ratio dropped from 440 deaths per 100,000 live births in 1990 to 240 in 2010, progress remains slow and there are growing disparities in knowledge about and access to reproductive health care, particularly among poor and rural women and members of vulnerable groups. As a result, the target of reducing maternal mortality by three quarters by 2015 is out of reach, particularly in sub-Saharan Africa. Reductions in adolescent childbearing and the expansion of contraceptive use have continued, but the pace of improvements was slower in the 2000s than in the previous decade. One of the main contributors to reductions in maternal mortality has been the increase in the proportion of deliveries attended by skilled personnel, which rose from 55 per cent in 1990 to 65 per cent in 2010.

15. While enrolment rates have increased in all regions, 61 million children of primary-school age were still out of school in 2010, with more than half of them (33 million) in sub-Saharan Africa and a fifth (13 million) in South Asia. Increasing completion rates in primary school have increased demand for secondary education. Countries facing budget constraints have been unable to meet the demand through the commensurate expansion of secondary education services, causing the dropout of large numbers of adolescents of lower-secondary-school age. Girls are disproportionately affected.[11]

16. While the use of unimproved water sources declined to 4 per cent in urban areas worldwide in 2010, 19 per cent of the world's rural population could gain access only to such unsafe sources. Since the dimensions of safety, reliability and sustainability are not adequately reflected in the proxy indicator used to track progress towards the relevant Millennium Development Goal target, it is likely that those figures underestimate the actual number of people using unsafe water supplies. Nearly half of those living in developing regions (2.5 billion) still lack access to improved sanitation facilities. At the current pace, the world will have reached only 67 per cent coverage by 2015, short of the 75 per cent needed to achieve the Millennium Development Goal target. And despite a 271 million reduction in this population since 1990, 1.1 billion people still practice open defecation. Entire communities are exposed on a daily basis to the considerable health and environmental hazards of inadequate human waste disposal.

17. Progress on the achievement of the environmental Goals looks rather poor. Global emissions reached 30.1 billion metric tons in 2009, which is still 39 per cent above the 1990 level of 21.7 billion metric tons. But total global emissions decreased slightly in 2009 from 30.2 billion metric tons in 2008. This decrease has been attributed to the slight reduction in productivity due to the global crisis.

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[10] See *Women in Politics: 2012*, Inter-Parliamentary Union, United Nations Entity for Gender Equality and the Empowerment of Women (New York, 2012).

[11] See *World Atlas on Gender Equality in Education*, United Nations Educational, Scientific and Cultural Organization (Paris, 2010).

18. The overexploitation of marine fisheries continued and reached a new peak in 2008, when the share of overexploited fish stocks shot up to 32 per cent.

19. Peace and conflict remained major issues in 2010 and 2011. Violence has become one of the largest obstacles to development, hence hampering progress towards the Millennium Development Goals. Approximately one fifth of humanity lives in countries experiencing significant violence, political conflict, insecurity and societal fragility.[12] A total of 4 million people were uprooted in 2011. This increase in the number of refugees was triggered largely by the post-election violence in Côte d'Ivoire, ongoing violence in Somalia and the Arab Spring uprisings. Four out of five of the refugees fleeing those situations are hosted by developing countries.

III. Achieving the Millennium Development Goals requires stable, equitable and inclusive growth

20. The 2008-2009 economic and financial crisis and the surge in food and energy prices caused a serious setback in the global efforts to achieve the Millennium Development Goals, and the global economy is still struggling to overcome the impact of the crisis. Growth remains sluggish in developed countries, which is also impeding economic progress in developing countries. Significant risks threaten the cautious recovery, leading to uncertain prospects for employment generation.[13] As a result, unemployment remains high and the global jobs crisis is deepening: 200 million people are unemployed worldwide, while 900 million workers live in poverty despite having some form of employment. In total, one in three workers globally is either un- or underemployed or lives in a family whose per capita income is less than $2 a day.[14]

21. Work is a central aspect of people's well-being. It is not only their main source of income, but also a source of human dignity and sense of self-worth, determining social relations and shaping identities. According to the World Bank, decent work provides an adequate amount of income to enable households to meet their basic needs and fosters broader social development by strengthening individuals, their families and their communities. Hence, the creation of decent and productive jobs is the critical link among economic growth, inclusive human development and shared prosperity. It is estimated that an additional 600 million jobs would need to be created over the next decade to address the backlog of unemployment and to provide employment for new labour market entrants. Young people as well as vulnerable populations, including persons with disabilities, people living with HIV[15] and women, are particularly affected by the jobs crisis.[14]

22. Persistent high unemployment is at the heart of the ongoing economic crisis in developed countries. Open unemployment rates are also high in some developing countries, but in most developing countries vulnerable working conditions and

[12] See *Global Burden of Armed Violence 2011: Lethal Encounters*, Geneva Declaration Secretariat (Cambridge, United Kingdom, 2011).

[13] See *World Economic Situation and Prospects as of mid-2012*, Department of Economic and Social Affairs (New York, 2012).

[14] See *Global Employment Trends 2012*, International Labour Organization (ILO) (Geneva, 2012).

[15] While 9 out of 10 people living with HIV are of working age, up to 40 per cent of survey respondents report employment loss due to their HIV status. See *26th Meeting of the UNAIDS Programme Coordinating Board*, UNAIDS (Geneva, 2010).

underemployment tend to be the more pressing labour market problems.[16] Workers, especially in least developed countries, find employment mainly in informal, low-productivity and low-wage activities and often lack any form of social protection. In 2011, more than 1.5 billion workers worldwide faced vulnerable employment conditions, as defined by the International Labour Organization.[14] This is nearly half (49.1 per cent) of the total number of workers in the world.

23. In order to address the jobs deficit and create sufficient, decent and productive employment for a growing labour force, economies will need to expand. Economic growth alone will not be sufficient. In the light of climate change and other environmental challenges and prevailing economic inequalities, growth patterns should become sustainable in terms of the use of natural resources and employment-intensive, as well as contribute to stronger productivity growth. Reorienting growth patterns will require not only that macroeconomic policies target employment generation more explicitly, but also that they be coherent with trade, investment, financial, industrial, rural development and social policies geared towards the creation of decent work for all and productivity growth that is environmentally sustainable.

A. Inclusive economic growth and productive employment

24. Macroeconomic policies are a core element of inclusive economic growth and employment creation. The recent economic problems in developed countries provide evidence as to the importance of macroeconomic stability and adequate policy responses to shocks and crises.

25. The ultimate goals of macroeconomic stabilization policies should be to achieve stable economic growth and facilitate employment creation. Price stability and sustainable levels of debt play an important role through their impact on investment decisions. In order to achieve these intermediate goals, countries need policy space for flexibility in the use of macroeconomic tools. These include countercyclical fiscal policy, a monetary policy regime supportive of both sustained growth and price stability, and an exchange rate regime that facilitates macroeconomic and structural adjustment supportive of sustainable job creation. These policies must be complemented by strong and prudent financial market regulation and supervision.

26. The details of any such policy mix are country-specific and need to be tailored to national circumstances. Successful implementation will require an enabling global policy environment and international policy coordination. The current world economic conditions require more short-term fiscal stimulus to break the cycle of high unemployment, weak aggregate demand and slow growth. Reorienting Government spending to overcome infrastructure bottlenecks and to promote sustainable agriculture, energy generation and, especially in primary-export-dependent economies, economic diversification tends to have strong and immediate employment effects, while improving long-run growth prospects.[13] In particular, investments in the renewable energy sector, which tends to be more labour-intensive than current energy generation technologies, provide a double benefit, placing

[16] ILO defines vulnerable employment as own-account or unpaid family work. Both are characterized mostly by difficult working conditions and low incomes (see *Global Employment Trends 2012*).

economies on not only a more sustainable but also a more employment-intensive growth path.[17] Macroeconomic policies can thus make important contributions by harnessing structural change and shifting resources — both labour and capital — to activities with higher productivity and thus greater potential for adequate remuneration. Yet, they are not sufficient. A coherent set of trade, investment, financial, industrial, education and social policies all have a role to play in facilitating structural change and placing economies on a more sustainable and employment intensive growth path.

27. The entry of private firms into new fields of endeavour often creates positive synergies. Initial investments in new and dynamic industries provide examples for other entrepreneurs, lead to the training of workers and young graduates, build up technological capacity and create demand for inputs and activities that might not yet exist domestically. Many of the gains will not be earned if fully left to market forces, however, given the costs of initiating new technological developments and other factors, such as the failure of markets to take environmental costs into account. Governments will have an important role to play in promoting socially relevant innovation. They can do so by supporting specific sectors and providing preferential access to finance and credit, temporarily guaranteeing market shares or access to inputs through flexible trade policies, providing access to research and technology, and implementing other measures tailored to their specific national contexts.

28. While technologically sophisticated modern services and manufacturing offer promising growth potential and prospects of employment creation, efforts to support those sectors must be accompanied by continued support for agriculture. The agricultural sector remains the major source of income, food and work for a majority of the poor in developing countries. Productive agriculture plays an important role in the early phase of structural transformation. Higher agricultural productivity not only increases the incomes of smallholder farmers, but also can create jobs and increase on-farm and non-farm incomes in rural areas owing to the high labour intensity of agriculture, while agro-processing reduces post-harvest losses and thus promotes food security. Public support to facilitate productivity increases is critical, including investments in rural infrastructure and agricultural science, technology and innovation, education and extension services, as well as greater access to credit and financial services, inputs, insurance, markets, land and secure property rights, in particular for women and vulnerable populations.

B. Creating decent and productive jobs: investing in skills and social protection

29. Investments in the skills development of the workforce, minimum wage systems and employment protection legislation can all contribute to conditions for decent work and foster broader social development. The minimum wage and employment protection legislation are sometimes seen as introducing rigidities into labour markets and causing low levels of formal sector employment. Yet, research shows that regulations aimed at protecting labour rights provide a tangible social benefit — lower inequality — without creating any significant loss in terms of

[17] See *Green Jobs: Towards Decent Work in a Sustainable, Low-Carbon World*, United Nations Environment Programme (Nairobi, 2008).

output and employment.[18] Labour mobility — between rural and urban areas, between sectors and industries and between the formal and the informal sector — depends more on enabling factors such as quality education, skills and knowledge, infrastructure and transportation systems, affordable housing, appropriate regulations and access to capital. Health, nutrition and basic education are important foundations for the fostering of a productive workforce. In order to increase labour mobility and decent work opportunities, countries need to place priority on measures that strengthen those enabling factors.

30. Workers in the informal sector, including the self-employed, often lack access to safety nets and other forms of social protection and work under conditions that do not meet international labour standards. They are extremely vulnerable to economic and weather-related shocks, and any loss of income can lead to a loss of assets with longer-term negative impacts. Integrating informal workers into fiscally sustainable universal social protection systems is critical in order to avoid long-term losses of human development as a result of short-term shocks. Such social protection can be effectively provided through combinations of programmes ensuring universal access to essential social services, providing income and in-kind transfers to vulnerable workers, unemployment and disability benefits, subsidized old-age pensions and universal access to reproductive and other basic health care. Universal systems of social protection, as promoted in the Social Protection Floor Initiative, complement programmes promoting inclusive economic development and tend to support social mobility. It is critical that they be available to people in both the formal and informal sectors if a two-tier approach is to be avoided. Brazil's Unified Health System, created in 1989, successfully merged two previous systems in order to unify health benefits for all citizens, including the majority of those in the informal sector.

31. The enormous scope of the employment challenge has prompted some Governments to introduce public employment programmes, which provide cash, food or other in-kind transfers for those unable to find any form of employment. They also allow for the targeting of disadvantaged groups that might be difficult to reach through other policy measures.[19] In addition, public works programmes provide social protection in times of economic crisis. They often include the building of infrastructure and other productive community assets that can enhance productive capacity and create better opportunities for investment and employment. Such programmes are currently being implemented in many sub-Saharan African countries, but they have also been used to address the consequences of climatic shocks in South Asia and Latin America.

32. In an environment of chronic unemployment or underemployment, permanent programmes offer a more sustained impact. In employment guarantee schemes, Governments act as the employer of last resort, guaranteeing employment and income for a minimum number of days a year. India's National Rural Employment Guarantee Act is the most prominent example; it guarantees a maximum of 100 workdays a year to every household at a minimum wage rate. The Government of South Africa reports that its Expanded Public Works Programme, in place since 2004, provides short-term employment for an average duration of 100 days and has

[18] See "Labour market institutions around the world", Richard B. Freeman (Cambridge, United Kingdom, 2007).

[19] See E/2012/33.

been continuously expanded since its inception. By 2014, the Programme aims to create more than 1.5 million work opportunities annually.

33. Such programmes, which reduce poverty and help workers make the transition to more stable forms of employment, require careful assessment of the local context so that their design can be adapted to meet specific needs.

C. Small and medium-sized enterprise development and job creation

34. Small and medium-sized enterprises tend to be a key driving force for economic growth, job creation and the provision of livelihoods in most developing countries, but they face a number of challenges that undermine their competitiveness and sustainability. The lack of physical and non-physical infrastructure in many developing countries places small and medium-sized enterprises at a significant disadvantage and can limit their access to export as well as domestic markets, their linkages to larger companies and their integration into international production networks. Formal registration is often costly, and all too frequently small and medium-sized enterprises are subject to the rent-seeking behaviour of public officials. Without assets that can serve as collateral, such enterprises do not fulfil the lending conditions required by most banks, while microfinance institutions typically do not provide loans of the required size. In terms of entrepreneurial aspects, many small and medium-sized enterprises also lack the management skills and business know-how to engage in innovation. In the absence of innovation and when concentrated in existing markets, the expansion of small and medium-sized enterprises tends to lead to an oversaturation of markets, thus reducing profit margins and employment prospects.

35. Therefore, if small and medium-sized enterprises are to provide decent livelihoods, Governments must put in place a range of coherent support measures that respond to their specific needs, providing access to inputs, credit and markets as well as addressing supply-side constraints through skills training. Improvements in infrastructure are necessary to ensure a reliable and steady power supply, efficient transportation links and roads, and access to information and communications technologies. At the macrolevel, there is a need for a robust and stable economic policy framework that promotes innovation and growth while minimizing volatility and uncertainty and facilitating access to private finance. Access to credit can also be enhanced through the direct provision of credit by public financial institutions and the provision of guarantees for certain kinds of credit and joint public-private sources of financing.[20]

36. Governments can facilitate market access by reserving a minimum percentage of Government tenders for small and medium-sized enterprises, by not imposing a minimum size requirement on enterprises bidding for projects, and by actively recruiting enterprises for smaller projects or to be participants in larger ones. Building clusters of small and medium-sized enterprises active in a particular field can be a helpful step towards their empowerment.

[20] See "Small and medium enterprises (SMEs) as drivers of productive capacity and job creation in Africa: regional preparatory meeting for Africa", Economic and Social Council (Addis Ababa, 2012).

37. Skills and training programmes relevant to small and medium-sized enterprises can be provided by expanding national educational curricula to include vocational and business training, by enhancing opportunities, especially for those in the informal sector, to gain access to vocational training,[21] and by involving institutions and entrepreneurs more systematically in public/private partnerships.

D. Youth unemployment as central to social and economic stability

38. The level of youth unemployment in developed and developing countries reached a new high in 2011, with nearly 75 million young people among the ranks of the unemployed. Projections for 2012 show no improvements,[22] and in many countries a growing number of young people are neither in school nor employed. Better educated than ever before, youth are struggling to find decent employment, which leaves many of them frustrated and disillusioned at their job prospects. Youth unemployment has major and long-term socioeconomic consequences, decreasing lifetime earning capacity and potential growth[19] and threatening social cohesion.

39. Addressing youth unemployment requires faster and stable economic growth in sectors with the potential to absorb young workers. At the same time, Governments need to ensure that young people possess adequate skills when they enter the labour market. Because of a mismatch between the demands of the labour market and educational curricula, which often lack vocational and skills-enhancing education, the school-to-work transition proves challenging for young men and women. Curricula need to provide the skills valued by employers, and it is important that they not reinforce gender stereotypes, but rather enable young women and men to follow non-traditional career paths. Paid internships and public-private programmes aimed at stimulating youth employment have proved important in reducing the barriers faced by young workers, which often include negative attitudes on the part of employers.

40. Educational policies should provide young people with adequate and practicable opportunities for on-the-job training, information about the labour market and assistance in finding a job. Such policies require close cooperation among Governments, the private sector and trade unions. Local governments, in cooperation with national Governments, must put in place policies and resources that support local economic development initiatives with a strong focus on youth and provide incentives for the private sector to hire young people.

IV. Delivering on the global partnership for development[23]

41. Millennium Development Goal 8 sets out commitments aimed at strengthening the global partnership for development in order to support national development efforts in five priority areas: official development assistance (ODA); the development of an open, rules-based, predictable, non-discriminatory trading and

[21] See "Promoting productive capacity, employment and decent work in Asia and the Pacific: a regional approach to sustained, inclusive and equitable growth and achieving the MDGs", Economic and Social Council (Kyoto, Japan, 2011).

[22] See *Global Employment Trends for Youth 2012*, ILO (Geneva, 2012).

[23] Unless otherwise noted, this section draws from information provided by the Millennium Development Goals Gap Task Force.

financial system; the management of the debt burden of developing countries; ensuring access to affordable essential medicines; and ensuring the availability of new technologies in cooperation with the private sector.

42. The ongoing protracted crisis is having a negative impact on ODA, which in 2011 fell nearly 3 per cent from its peak in 2010. The total amount of ODA provided by countries members of the Development Assistance Committee totalled $133.5 billion in 2011, equivalent to 0.31 per cent of their aggregate gross national income (GNI). ODA flows will have to more than double in order to meet the United Nations target of 0.7 per cent of donor GNI. All donors should honour their commitments to increase aid, provide multi-year spending plans and make aid more effective.

43. The Doha Round, after 11 years of negotiations, remains at an impasse. Concluding the Doha Round is crucial to addressing structural imbalances in the global trade regime, and countries are urged to increase efforts to finalize the negotiations. While the ongoing economic and financial crisis continues to slow the pace of global trade, the exports of developing countries have recovered more strongly in the current crisis than those of developed countries. Even so, least developed countries face constant difficulties in expanding their trade as the progress made in gaining duty-free and quota-free market access in developed countries has slowed. Neither the 2005 Hong Kong Declaration aimed at providing such access for all products of least developed countries nor simplified rules of origin have yet been fully implemented. There is an urgent need to remove all trade-restrictive measures introduced since the onset of the global economic crisis, as those measures have affected nearly 3 per cent of world trade. Such trade restrictions further limit the growth prospects and opportunities for job creation in developing countries. At the same time, trade capacities in developing countries need to be strengthened, including through the enhancement of the Aid for Trade initiative, while ensuring that it incorporates the key principles of aid effectiveness and support for countries in integrating trade strategies into their overall national development strategies.

44. The Heavily Indebted Poor Countries Initiative, providing debt relief to a selected number of countries, will soon be concluded. By May 2012, 36 of the 39 participating countries had reached the "decision point" under the initiative, and 32 of these had reached the "completion point". At the same time, however, roughly 20 developing countries remain in or at high risk of debt distress, and the average debt service to export ratio for developing countries in 2011 increased slightly to 26.4 per cent. This slight increase was due mainly to lower-middle-income countries, while there are signs of renewed vulnerability in some low-income countries. Hence, options for the enhancement of the international architecture for debt relief should be explored at the global level. Moreover, a number of policy options can help to mitigate the impact of high external debt burdens. At the national level, these include the strengthening of debt management capacities, which would allow for improved debt sustainability analyses. At the global level, the impact of litigation brought by creditors not participating in international structures needs to be reduced, and a discussion on proposed principles for responsible borrowing and lending should be initiated, together with a discussion on the development of guidelines regarding foreign debt and human rights.

45. Improved access to affordable essential medicines would help to accelerate the progress being made on the achievement of the health-related Millennium Development Goals. Only 51.8 per cent of public and 68.5 per cent of private health facilities in developing countries stock essential medicines, while average medicine prices are 2.6 times higher in the public sector and 5 times higher in the private sector in comparison with international reference prices. The Governments of developing countries require assistance in increasing the availability of essential medicines through the public sector, particularly in cases of public health emergencies, to ensure affordable access for those in need.

46. Wider use of the trade-related provisions set out in the intellectual property rights regulations of the World Trade Organization, together with greater use of innovative mechanisms to lower costs and increase access to essential medicines in low- and middle-income countries, should be pursued as part of global efforts in this area.[24] Lowering the cost of medicines needs to be complemented with the strengthening of health systems in developing countries, an increase in the local production of generic medicines and better regulatory capacities to ensure the safety, efficacy and quality of medicines. More should be done to provide adequate incentives for research and development with regard to new medicines, particularly for neglected diseases.

47. While access to new technologies continues to expand globally, especially in the area of information and communications technology, the global digital divide remains vast. The majority of people living in least developed countries lack access to the Internet. For many people in developing countries, mobile broadband is often the only medium for Internet access and the costs of information and communications technology are higher, especially in Africa. There is still a need to pick up the pace of efforts to increase access to and the affordability of the Internet, in cooperation with the private sector. Steps towards this goal include adopting national broadband policies, increasing infrastructure and expanding connectivity in order to provide universal access. Access to green technologies and technologies for climate change mitigation and adaptation, disaster risk reduction and resilience are needed. Against this backdrop, Governments are urged to fully operationalize and capitalize the Green Climate Fund and to support the effective implementation of the Technology Mechanism. Much more work is required in order to build the innovation and absorptive capacity of developing countries to facilitate the transfer, adaptation and dissemination of these technologies.

48. In the three years left before the 2015 deadline for meeting Millennium Development Goal targets, more specific interventions will be needed in developing countries to accelerate progress on the various dimensions of the Goals, but without an enabling global environment the promise offered by the Goals will remain unfulfilled. Closing the gap in the delivery of stable and effective ODA flows; making faster progress towards the establishment of an open, rules-based, predictable and non-discriminatory trade and financial system; providing access to affordable essential medicines; and making available the benefits of new technologies, in accordance with the explicit commitments made by developed countries under Millennium Development Goal 8, are all critical ingredients towards the achievements of the Goals.

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[24] Innovative mechanisms include the Medicines Patent Pool initiative and voluntary licensing by pharmaceutical companies.

V. United Nations development agenda beyond 2015

49. There is a recognized need to begin thinking about the United Nations development agenda beyond 2015, building on the experience gained with the Millennium Development Goals framework. Some Member States have launched national initiatives to inform discussions on this topic, which have seen the participation of a number of civil society organizations from all over the world. Academic and other research institutions have been particularly active, and the private sector is also involved.

A. Emerging areas of focus in discussions on the post-2015 United Nations development agenda

50. In the discussions engaged in so far, four broad areas of focus have emerged: the consultation process for the formulation of the post-2015 United Nations development agenda; substantive themes for consideration; the format or design of the agenda; and the monitoring of progress and accountability for results.

51. There is consensus regarding the need for an open and inclusive consultation process, led by Member States and engaging all stakeholders, as well as the need to support the capacity of least developed countries and poor or marginalized people to participate in it. The importance of other intergovernmental processes informing the discussions has also been emphasized. Particular attention has been drawn to the United Nations Conference on Sustainable Development, as discussed further below.

52. In respect of substantive themes, support has been expressed for a post-2015 United Nations development agenda that builds on the Millennium Development Goals framework and keeps the focus on human development, while addressing emerging challenges. However, the need not to overload the agenda is also being highlighted.

53. Such a focus and format are also seen as critical in addressing the issues of monitoring and accountability. Various ways of measuring progress are being discussed, including ways of addressing inequalities, in part through the more effective use of disaggregated data.

B. Ongoing processes and inclusive national, regional and global consultations

54. In its global convening role, the United Nations can bring together the various sets of stakeholders that can contribute to the global development agenda beyond 2015. The Secretary-General has established the United Nations system task team on the post-2015 United Nations development agenda, to support the consultation process, coordinate system-wide preparations and define a system-wide vision and possible road map to support deliberations on a post-2015 development agenda. Launched in January 2011 and led by the Department of Economic and Social Affairs and the United Nations Development Programme, the task team brings

together some 60 United Nations agencies and other international organizations. The team submitted its first report to the Secretary-General in June 2012.[25]

55. The report contains the task team's main findings and recommendations with regard to a new vision for development aimed at generating transformative change, the possible contours of such an agenda and options for moving forward in the consultation process, including ways to bring in the voices of various stakeholders. Those recommendations are made in the light of analysis of the strengths and weaknesses of the Millennium Development Goals framework and assessment of the lessons learned for the post-2015 United Nations development agenda, as well as the outlining of emerging and existing pressing global challenges that must be taken into account.

56. As indicated in the report, the Millennium Declaration can serve as the starting point for the discussion on the post-2015 United Nations development agenda, as the values and principles that it reflects are as relevant today as they were in 2000.[26] The agenda should also build on the experience gained with the Millennium Development Goals framework and recognize the advantage of keeping an inspirational, concise and easy-to-articulate format.[27]

57. In addition to maintaining a clear focus on human development, the post-2015 development agenda will have to address other emerging or pressing challenges. The report of the task team analyses a range of challenges, from an increasing environmental footprint with increasing disaster risks to rising inequalities, continuing violent conflict, rapid demographic change, rapid urbanization and continuous migration flows. There is also the knowledge gap between and within countries and governance and accountability deficits at various levels that require the strengthening of compliance with the rule of law. Food and nutrition security; water and sanitation; energy; and access to quality health services (including reproductive health), education and vocational training are also of crucial importance.[28]

58. The world cannot continue on its current course. There is a need for an agenda aimed at transformative change leading to a shared, secure and sustainable future for all. The report of the task team sets out a vision for such an agenda, guided by the three fundamental principles of human rights, equality and sustainability. It proposes four interconnected core dimensions that can serve as the basis for the definition of goals and targets:

(a) Inclusive social development;

(b) Environmental sustainability;

(c) Inclusive economic development;

(d) Peace and security.

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[25] *Realizing the Future We Want for All: Report to the Secretary-General*, United Nations system task team on the post-2015 United Nations development agenda (New York, 2012).

[26] See General Assembly resolution 55/2.

[27] For an in-depth analysis, see *Review of the Contributions of the MDG Agenda to Foster Development: Lessons for the Post-2015 UN Development Agenda*, United Nations system task team on the post-2015 United Nations development agenda (New York, 2012).

[28] Members of the United Nations system task team have prepared think pieces on emerging challenges; see http://www.un.org/millenniumgoals/beyond2015.shtml#Resources.

Principles and goals should guide policy choices at various levels without becoming prescriptive and while recognizing differences in initial conditions. To support the implementation of the agenda, the global partnership for development would need to be strengthened as a responsibility shared by all countries and involving all stakeholders through a well-defined accountability framework.

59. The task team's report, which has been made publicly available, is intended to serve as a reference for further broad and inclusive consultations on the post-2015 United Nations development agenda to be held in the coming years. The report will also inform the work of the High-level Panel of Eminent Persons, launched by the Secretary-General on 31 July 2012 to provide further support for the consultation process.

60. The United Nations Development Group has launched a complementary project in support of open and inclusive consultations on the post-2015 United Nations development agenda. National consultations aimed at engaging stakeholders in some 50 developing countries are being planned for 2012 through mid-2013, to be complemented by global and regional thematic meetings as well as social media and other forms of outreach.

C. The way forward

61. The outcome of the 2010 High-level Plenary Meeting of the General Assembly on the Millennium Development Goals, including the mandate to begin thinking about how to advance the United Nations development agenda beyond 2015, also included a call for the President of the General Assembly to convene a special event in follow-up to the Meeting at its sixty-eighth session, which will begin in September 2013. The special event, which should devote particular attention to accelerating progress towards the Millennium Development Goals during the final stretch to 2015, is also seen as a key milestone in the deliberations on the post-2015 United Nations development agenda. As such, the event could be used as the basis for a possible road map towards the formulation of the agenda, following a two-step approach.

A two-step approach

62. The first step, from now through the fall of 2013, would include a broad discussion about the purpose and scope of the post-2015 United Nations development agenda, and would greatly benefit from an open, inclusive and transparent consultation process with contributions from a wide range of stakeholders. The consultations would provide a strong basis for the second step, from fall 2013 through 2015, involving intensified efforts to achieve an intergovernmental consensus regarding the post-2015 development agenda. Negotiations during this step would lead to the identification of concrete goals and targets, with an open and inclusive process being maintained.

63. The special event could play an important role in providing the basis for subsequent decision-making on the characteristics and content of the post-2015 development agenda. It could include multi-stakeholder participation, with the objective of providing a platform for interactive dialogue among Member States and other stakeholders about the broad contours of the post-2015 United Nations development agenda. Another objective of the event could be to generate a call and

a road map for a high-level plenary meeting of the General Assembly in 2015 aimed at reaching agreement on this agenda.

64. During the second step, as a consensus regarding the form and content of the agenda takes shape, preparatory work at various levels could be initiated on monitoring and evaluation systems, accountability mechanisms and the mobilization of resources to support implementation. This could also be the time to begin work on defining a coherent United Nations system approach to support implementation.

65. The development of indicators, including methodology and indicator selection, and the provision of advice regarding the technical aspects of target-setting could both be assigned to an inter-agency expert group, with guidance from the Statistical Commission, as has been the case with the Millennium Development Goals framework.

Links to other intergovernmental processes, including follow-up to the United Nations Conference on Sustainable Development

66. Special attention should be placed on ensuring that relevant intergovernmental processes feed into the discussions on the post-2015 United Nations development agenda, particularly in terms of identifying priority areas.[29] For example, the Follow-up International Conference on Financing for Development to Review the Implementation of the Monterrey Consensus, the 2014 Development Cooperation Forum and the report to the General Assembly on a sustainable development financing strategy would provide opportunities for, in particular, a multi-stakeholder discussion on reshaping the global partnership for development to support the implementation of a post-2015 global development agenda.

67. In the coming weeks, the focus should be placed on establishing how the results of the United Nations Conference on Sustainable Development should inform the discussions on the post-2015 United Nations development agenda[30] and the linkages between the follow-up to the Conference and the post-2015 process. This would address the widely shared need to work towards one unified global development agenda for the post-2015 period, with sustainable development at its centre.

68. In the outcome of the United Nations Conference on Sustainable Development, Member States agreed to launch an inclusive intergovernmental process aimed at developing a set of sustainable development goals that should "incorporate in a balanced way all three dimensions of sustainable development and their interlinkages" and "should be coherent with and integrated into the United Nations development agenda beyond 2015".[31] Building on the experience gained with the Millennium Development Goals framework, they agreed that the sustainable development goals "should be action-oriented, concise and easy to communicate, limited in number, aspirational, global in nature and universally applicable to all countries while taking into account different national realities, capacities and levels of development".[32] They also decided to establish an open working group with

[29] An indicative list of these processes can be found in *Realizing the Future We Want for All: Report to the Secretary-General* (New York, 2012), annex 3.

[30] See General Assembly resolution 66/288.

[31] General Assembly resolution 66/288, para. 246.

[32] Ibid., para. 247.

30 representatives of Member States by the time of the opening of the sixty-seventh session of the General Assembly, in order to prepare a proposal on sustainable development goals for submission to the Assembly at its sixty-eighth session.

69. The convergence of the two processes, aimed at defining the sustainable development goals and the post-2015 United Nations development agenda, could be achieved through the guidance and decisions of the General Assembly. To this end, the Assembly could consider making use of the special event to be held in the third quarter of 2013 to place the two processes on a common track, with a view to making a determination regarding the post-2015 United Nations development agenda, including sustainable development goals.

70. To support the convergence of the sustainable development goals process and the post-2015 process, the following specific measures could be taken by Member States, the United Nations system and other stakeholders:

(a) The regional, national and thematic consultations on the post-2015 United Nations development agenda should help to build the bridge between discussions on sustainable development goals and discussions on the post-2015 United Nations development agenda, of which the sustainable development goals will be an integral part;

(b) Simultaneous consultations on sustainable development goals and the post-2015 United Nations development agenda would provide important stakeholder and expert inputs for the work of the intergovernmental open working group on sustainable development goals, as defined in the outcome of the United Nations Conference on Sustainable Development;

(c) Additional efforts should be made to ensure that preparations for and consultations in advance of the 2013 special event convened by the President of the General Assembly in follow-up to the 2010 High-level Plenary Meeting of the Assembly on the Millennium Development Goals encourage further bridge-building between the sustainable development goals process and the post-2015 process;

(d) There should be close interaction at the level of the Secretariat in support of the two processes.

71. To support the sustainable development goals process and the work of the intergovernmental open working group, the outcome of the United Nations Conference on Sustainable Development requested the Secretary-General "to ensure all necessary input and support to this work from the United Nations system, including through establishing an inter-agency technical support team and expert panels, as needed, drawing on all relevant expert advice".[33] The Secretary-General will establish such a technical support team under the umbrella of the United Nations system task team on the post-2015 United Nations development agenda. The task team, comprising 60 agencies and other entities, includes the members of the "ECESA plus" platform, which served as the United Nations system coordination mechanism for the Conference preparations.

[33] Ibid., para. 249.

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Advancement of women

Supporting efforts to end obstetric fistula

Report of the Secretary-General

Summary

This report is prepared in response to General Assembly resolution 65/188. Obstetric fistula is a devastating childbirth injury that leaves women incontinent, often stigmatized, and isolated from their communities. It is a stark outcome of socioeconomic and gender inequalities, human rights denial and poor access to reproductive health services, including maternal and newborn care, and an indication of high levels of maternal death and disability. The report outlines efforts made at the international, regional and national levels, and by the United Nations system, to end obstetric fistula. It offers recommendations to intensify these efforts, within a human rights-based approach, to end obstetric fistula as a key step towards achieving Millennium Development Goal 5, by improving maternal health, strengthening health systems, reducing health inequities, and increasing the levels and predictability of funding.

* A/67/150.

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I. Introduction

1. This report is submitted in accordance with General Assembly resolution 65/188, in which the Assembly requested the Secretary-General to submit to it at its sixty-seventh session a report on the implementation of the resolution under the item entitled "Advancement of women".

2. Sexual and reproductive health problems remain the leading cause of ill health and death for women of childbearing age worldwide. Impoverished women, particularly those in developing countries, suffer disproportionately from limitations on their right of access to health care, from unintended pregnancies, maternal death and disability, sexually transmitted infections including HIV, cervical cancer, sexual and gender-based violence, and other problems related to their reproductive system. Educating and empowering women and girls are crucial for their well-being, and fundamental for preventing obstetric fistula and improving maternal health. Educated women and girls better understand how to exercise their reproductive health choices, the benefits of seeking appropriate care during pregnancy and delivery, why to delay marriage until adulthood and how to ensure the well-being of their children and families.

II. Background

3. Obstetric fistula is a severe maternal morbidity which can affect any woman or girl who suffers from prolonged or obstructed labour without timely access to an emergency Caesarean section. It is one of the most devastating consequences of neglected childbirth and a stark example of health inequity in the world. Although obstetric fistula has been eliminated in industrialized countries, it continues to afflict the most impoverished women and girls in the developing world, mainly those in rural and remote areas. Eliminating obstetric fistula as a global health problem necessitates scaling up country capacity to provide access to comprehensive emergency obstetric care, treat fistula cases, and address underlying medical, socioeconomic, cultural and human rights determinants. To end obstetric fistula, countries must ensure universal access to reproductive health services; eliminate gender-based social and economic inequities; prevent child marriage and early childbearing; promote education and broader human rights, especially for girls; and foster community participation in finding solutions, including through the active involvement of men.

4. The medical and social consequences of obstetric fistula can be life-shattering for women, their children and families. In almost 90 per cent of fistula cases, the baby is stillborn or dies within the first week of life.[1] If a woman survives prolonged or obstructed labour, she may be left with a severe, disabling injury in her birth canal. A woman with fistula is not only left incontinent but may also experience neurological disorders, orthopaedic injury, bladder infections, painful sores, kidney failure or infertility. The odour from constant leakage combined with misperceptions about its cause often results in stigma and ostracism by communities. Many women with fistula are abandoned by their husbands and families and are excluded from daily family and community life. They may find it

[1] L. L. Wall et al., "The obstetric vesicovaginal fistula: characteristics of 899 patients from Jos, Nigeria", *American Journal of Obstetrics and Gynecology*, vol. 190, No. 4 (April 2004).

difficult to secure income or support, thereby deepening their poverty. Their isolation may affect their mental health, resulting in depression, low self-esteem and even suicide.

5. While precise figures are not available, it is generally accepted by the United Nations that from 2 million to 3.5 million women and girls live with obstetric fistula.[2] Determining the prevalence and incidence, however, is extremely difficult as fistula usually afflicts the most marginalized — poor, young, often illiterate women and girls living in rural areas — and usually requires clinical screening to diagnose.

6. Obstetric fistula can be prevented. Tackling the root causes of maternal mortality and morbidity is essential, including poverty, gender inequality, barriers to education — especially for girls — child marriage and adolescent pregnancy. It requires functioning, accessible health systems. It needs adequately trained professionals, reliable access to essential medicines and equipment, and equitable access to high-quality reproductive health services.

7. Broader economic and sociocultural changes are required to prevent obstetric fistula. Poverty and gender inequality impede women's opportunities, including access to health services. Culture also influences the status of their sexual and reproductive health, the age of marriage, the spacing and number of children. Traditions favouring unassisted home delivery, including the use of unskilled traditional birth attendants and harmful practices such as female genital mutilation and child marriage further inhibit maternal health. Health-care costs can be prohibitive for poor families, especially when complications occur. These factors contribute to the three delays that impede women's access to health care: delay in seeking care; delay in arriving at a health-care facility; and delay in receiving adequate care once at the facility.

8. Adolescent girls are particularly at risk of maternal deaths and morbidities, including obstetric fistula. Although adolescent births represent approximately 11 per cent of births worldwide, they account for 23 per cent of the burden of disease among women of all ages.[3] Sixteen million adolescent girls give birth each year; almost 95 per cent of those births occur in developing countries.[4] Complications of pregnancy and childbirth are the leading cause of death among girls 15 to 19 years old in low- and middle-income countries. Evidence suggests that delaying pregnancy until after adolescence may reduce the risk of obstructed labour and obstetric fistula. Malnutrition among girls may stunt growth. Pregnancies that occur early, before the pelvis is fully developed, can increase the risk of obstructed labour.

9. Child marriage affects one in three girls in the developing world, predominantly the poorest, least educated girls living in rural areas. Although age at marriage is generally rising, millions of girls in developing countries are expected to marry before age 18.[5] Impoverished, marginalized girls are more likely to marry as

[2] Van Beekhuizen, Heleen J. et al., "Complications of obstructed labour: pressure necrosis of neonatal scalp and vesicovaginal fistula", *The Lancet*, vol. 368, issue 9542 (September 2006).

[3] World Health Organization (WHO), Department of Making Pregnancy Safer, *Adolescent Pregnancy*, MPS Notes, vol. I, No. 1 (2008).

[4] WHO, *Preventing Early Pregnancy and Poor Reproductive Outcomes among Adolescents in Developing Countries: WHO guidelines*, 2011.

[5] United Nations Population Fund, *Giving Girls Today and Tomorrow: Breaking the Cycle of Adolescent Pregnancy*, 2007.

children and give birth during adolescence than girls with greater education and economic opportunities. Child marriage is a key driver of early pregnancy and childbearing before adolescent girls are physically or emotionally ready, which heightens their risk of maternal death and morbidities, including fistula. Married adolescent girls often have difficulty accessing reproductive health services for reasons including social isolation and lack of awareness of their reproductive rights. All adolescent girls and boys, both in and out of school, married and unmarried, need access to comprehensive sexuality and human rights education, life skills education, and health services including sexual and reproductive health, to protect their well-being.

10. There is consensus in the global health community on the three most cost-effective interventions to reduce maternal mortality and morbidity, including obstetric fistula. They are: universal access to family planning; a trained health professional with midwifery skills at every childbirth; and timely access to high-quality emergency obstetric and newborn care. Prevention is a core component of effective strategies to end fistula, of which abandonment of harmful practices, such as child marriage, is crucial.

11. The same interventions that reduce maternal mortality reduce fistula. Several low-income countries, including Bolivia (Plurinational State of), Eritrea, Nepal, Rwanda and Yemen, have made progress in reducing maternal mortality over the past 10 years. In Afghanistan, antenatal care and skilled delivery coverage more than tripled from 2003 to 2010, thereby significantly reducing the maternal mortality ratio from an estimated 1,400 per 100,000 live births in 2008 to 460 in 2010.[6] The Islamic Republic of Iran, with a maternal mortality ratio of 30,[7] is one of 10 middle-income countries that have reached the Millennium Development Goal 5 target of reducing the maternal mortality ratio by three quarters by strengthening maternal health systems.[8] In Egypt, the Ministry of Health made reducing the maternal mortality ratio a national priority and concentrated on regions with the highest incidence of maternal death.[9] The maternal mortality ratio in Egypt declined from 230 in 1990 to 66 in 2010.[8] The Russian Federation has successfully cut its maternal mortality ratio by more than half over the past two decades, from 74 to 34. Algeria and Chile reduced their maternal mortality ratios by over 50 per cent from 1990 to 2010. The Arab States have made commendable progress, reducing the maternal mortality ratio by 65 per cent or more in Morocco, Oman and Yemen; around 50 per cent or more in Qatar, Tunisia and the United Arab Emirates; and over 40 per cent in Jordan, Libya and Saudi Arabia. Qatar and the United Arab Emirates have achieved maternal mortality ratios below those of many other countries, including the United States of America.[8]

12. Most cases of obstetric fistula can be treated through reconstructive surgery. Women can then be reintegrated into their communities with appropriate psychosocial care. However, research suggests that there is a huge gap between the need for fistula treatment and available services. Currently, few health-care facilities

[6] *Trends in Maternal Mortality: 1990 to 2010*. Estimates developed by WHO, UNICEF, UNFPA and the World Bank, 2012; Afghan Public Health Institute et al., *Afghanistan Mortality Survey*, 2010.

[7] See www.unicef.org/infobycountry/iran_statistics.html.

[8] *Trends in Maternal Mortality: 1990 to 2010*.

[9] See www.womendeliver.org/assets/Maternal_mortality_success_stories.pdf.

are able to provide high-quality fistula surgery, owing to the limited number of health-care professionals with the necessary skills. Facilities that do exist may not function at maximum capacity for lack of trained health professionals, equipment and life-saving medical supplies. When services are available, many women are not aware of, or cannot afford or reach the services, owing to such barriers as transportation costs. A global fistula mapping exercise conducted in 2010 by Direct Relief International, the Fistula Foundation and the United Nations Population Fund (UNFPA) found that fistula treatment reaches only a fraction of fistula patients annually — approximately 14,000 cases compared to the estimated 50,000 to 100,000 new cases each year[2] — highlighting the need for intensifying resources to bridge this large gap.[10]

13. UNFPA launched the global Campaign to End Fistula in 2003, with partners, with the goal of making fistula as rare in developing countries as in the industrialized world. The Campaign focuses on three key strategies: prevention, treatment and social reintegration. It is active in over 50 countries in Africa, Asia, the Arab States and Latin America and brings together more than 75 partner agencies at the global level and many others at the national and community levels. Since the Campaign began, UNFPA has directly supported over 27,000 women and girls to allow them to receive surgical treatment for fistula, and partners such as EngenderHealth supported thousands more.[11] As the tenth anniversary of the Campaign to End Fistula approaches, numerous challenges have still to be met. Many women and girls continue to suffer isolation for want of treatment. According to an independent evaluation in 2010, the Campaign has enhanced the visibility and knowledge of obstetric fistula worldwide, yet it is critically underresourced and requires far more financial and human resources to achieve its goal of eliminating fistula.

14. UNFPA serves as the secretariat for the International Obstetric Fistula Working Group — the main decision-making body of the Campaign to End Fistula. The Working Group promotes effective, collaborative partnerships and generates consensus and evidence regarding effective strategies for preventing and treating fistula and reintegrating women living with fistula into society.

III. Initiatives at the international, regional and national levels

A. Major international initiatives

15. For more than two decades, the United Nations and the international community have campaigned to reduce maternal mortality and morbidity. Global commitments were first made in 1987 at the International Safe Motherhood Conference in Nairobi. The Programme of Action adopted at the International Conference on Population and Development in Cairo in 1994 recognized maternal health as a key component of sexual and reproductive health. In 1995, at the Fourth World Conference on Women in Beijing, Governments, adopting the Platform for Action, recognized entrenched patterns of social and cultural discrimination as major contributors to sexual and reproductive ill-health, including maternal death and disability. Member States have upheld the right of women and girls to the

[10] www.globalfistulamap.org.

[11] See www.endfistula.org.

highest attainable standard of mental and physical health, including sexual and reproductive health, through the Convention on the Elimination of All Forms of Discrimination against Women, the Convention on the Rights of the Child, the International Covenant on Economic, Social and Cultural Rights, and the Convention on the Rights of Persons with Disabilities.

16. In 2000, world leaders reaffirmed their commitment to improve maternal health, adopting Millennium Development Goal 5 to reduce the maternal mortality ratio by three quarters by 2015.[12] The target of universal access to reproductive health under Goal 5 ensures full coverage of all factors necessary for improving maternal health. Goals 3, 4 and 6 are also essential for women's health, well-being and survival. Achieving Goal 1, eradicating extreme poverty, will significantly contribute towards eliminating maternal mortality and fistula. In 2010, data showed for the first time good progress towards reaching Millennium Development Goal 5; however, an estimated 96 countries will not reach the target until at least 20 years after 2015 if the current pace continues.[13]

17. The General Assembly first recognized the problem of obstetric fistula in 2005 in its resolution 60/141 on the girl child. It identified early childbearing and limited access to sexual and reproductive health as key factors in the persistence of obstetric fistula and maternal mortality.

18. In 2007, the General Assembly for the first time acknowledged obstetric fistula as a major women's health issue by adopting resolution 62/138 on supporting efforts to eliminate obstetric fistula. In 2010 the Assembly adopted resolution 65/188, sponsored by a record-breaking 172 States, calling for renewed focus and intensified efforts for eliminating obstetric fistula. States reaffirmed their obligation to promote and protect the rights of all women and girls and to contribute to efforts to end fistula, including to the global Campaign to End Fistula.

19. Launched in 2008 by UNFPA and the International Confederation of Midwives, the Midwifery Programme helps countries to strengthen their midwifery programmes and policies. The programme aims to improve skilled attendance at all births in low-resource countries. It supports national midwifery training and education; developing strong regulatory mechanisms promoting quality midwifery services; strengthening and establishing midwifery associations; and advocating with Governments and stakeholders to encourage investment in midwifery services. The programme is active in over 30 countries in Africa, Asia, the Arab States and Latin America. More than 2,000 midwives have been trained and 150 midwifery schools provided with books, clinical training, equipment and supplies.

20. The High-level Plenary Meeting of the General Assembly on the Millennium Development Goals, in 2010, revealed that Millennium Development Goal 5 had the least financial support and lagged behind all other Goals. Of the 68 countries that account for most maternal and child deaths, only 16 per cent were on track to reach Goals 4 and 5 by 2015. In response, a Global Strategy for Women's and Children's Health was launched with the objective of saving the lives of more than 16 million women and children by 2015. The Global Strategy, or Every Woman Every Child,

[12] See A/56/326.

[13] Lozano, Rafael et al., "Progress towards Millennium Development Goals 4 and 5 on maternal and child mortality: an updated systematic analysis", *The Lancet*, vol. 378, issue 9797 (24 September 2011).

presents a road map to enhance health financing, strengthen policy and improve services on the ground for vulnerable women and children.

21. In 2011, the Human Rights Council adopted a landmark resolution on preventable maternal mortality and morbidity and human rights (resolution 18/2), applying a human rights-based approach to policies and programmes to reduce maternal mortality and morbidity.

22. The Commission on the Status of Women, in March 2012, adopted the biannual resolution 56/3, on eliminating maternal mortality and morbidity through the empowerment of women, calling for the elimination of preventable maternal mortality and morbidity and strengthening comprehensive health services for women and girls, including access to sexual and reproductive health.

23. Reaffirming the need to promote gender equality and the empowerment of girls and young women in all aspects of youth development, the Commission on Population and Development adopted resolution 2012/1.

24. In response to the substantial unmet need for family planning services worldwide and recognizing family planning as a key component of reproductive health, including fistula prevention, in July 2012, at the London Summit on Family Planning, donors committed over $4 billion for family planning. This initiative aims to give 120 million more women in developing countries access to voluntary family planning by 2020.

B. Major regional initiatives

25. Concerned about insufficient progress on Millennium Development Goals 4 and 5, the African Union, with United Nations support, has intensified efforts to improve sexual and reproductive health throughout Africa. In 2003, the African Regional Reproductive Health Task Force called for the development of national road maps to accelerate the reduction of maternal and newborn mortality. The plan, endorsed by the World Health Organization (WHO), UNFPA, UNICEF, the World Bank and others, aims to help Governments to plan and mobilize support for skilled attendance during pregnancy, childbirth and the postnatal period, and to strengthen national health systems. To date, more than 42 African countries have developed road maps, and 9 have conducted midterm reviews and created implementation plans.

26. In 2006, African Union Heads of State endorsed the Continental Policy Framework on Sexual and Reproductive Health and Rights. The Framework, or the Maputo Plan of Action, addresses reproductive health challenges in Africa and includes a substantial component on obstetric fistula, calling for health sector strengthening and increased resource allocations for health. While some progress has been made in implementing the Maputo Plan of Action, resources remain very limited, few countries having a budget line for sexual and reproductive health.[14] Leaders have extended the Maputo Plan of Action from 2010 to 2015.

27. The Campaign on Accelerated Reduction of Maternal Mortality in Africa promotes intensified implementation of the Maputo Plan of Action in Africa. UNFPA, UNICEF, WHO, bilateral donors and civil society organizations support the

[14] See www.unfpa.org/public/home/publications/pid/4197.

Campaign at the national and regional levels. The Campaign initiates policy dialogue, advocacy and community mobilization to secure political commitment, increase resources and effect societal change in support of maternal health at the country level.

28. At the regional conference on obstetric fistula and maternal health in Côte d'Ivoire in 2008, an African network of civil society organizations was launched. The network leverages technical and financial resources and promotes South-South cooperation to address obstetric fistula and promote maternal health.

29. In 2009, the Association of Southeast Asian Nations (ASEAN) adopted the Joint Declaration on the Attainment of the Millennium Development Goals in ASEAN, which includes the development and implementation of a road map for achieving the Millennium Development Goals. In 2011, the ASEAN Intergovernmental Commission on Human Rights organized a conference in the Philippines, which identified region-specific good practices for reducing maternal mortality and morbidity. It called for renewed efforts to improve maternal health with increased budget allocations, and legislation to promote women's right to reproductive health, including safe pregnancy and affordable family planning services.

30. Promoting the theme, "Neglected no more — dignity restored", UNFPA supported a regional conference on fistula in Pakistan in 2011 bringing together 1,200 participants from 14 countries, including 10 international fistula surgeons. The event was an important milestone in highlighting obstetric fistula in Pakistan and secured the strong commitment of the Pakistan Ministry of Health to establish a national task force for fistula.

31. The South Asian Association for Regional Cooperation (SAARC) initiated a regional project to reduce child and maternal mortality through improving the skills of health professionals, providing comprehensive mother-and-child primary health care and improving infrastructure and equipment at the district and subdistrict levels. The project is financed by the newly established SAARC Development Fund.

32. In the Latin American and Caribbean region, a Regional Inter-Agency Task Force for the Reduction of Maternal Mortality was established. It supports countries in implementing the recommendations of the WHO Commission on Information and Accountability for Women's and Children's Health. Members include United Nations agencies, bilateral donors, development banks, non-governmental organizations and medical professional associations.

33. South-South collaboration is a key strategy of the Campaign to End Fistula. Since 2010, UNFPA and its partners have supported the sharing of knowledge, skills and resources among many countries. The Niger welcomed a team of doctors and surgeons from Haiti; in Ethiopia the Hamlin Fistula Hospital treated complex fistula cases from the Sudan; and South Africa treated fistula cases from Swaziland. Bangladesh provided training on fistula surgery, management and counselling to health professionals in Nepal and performed complicated fistula surgeries on women in Timor-Leste. Doctors from Pakistan travelled to Kenya for training on new techniques in post-surgical incontinence. In Benin, UNFPA, in partnership with civil society and the USAID Integrated Family Health project, supported the training of fistula surgeons from Chad and Mauritania on the latest techniques in fistula repair. A Senegalese fistula surgeon performed fistula surgery in Chad, Gabon and Rwanda.

Lesotho sent fistula patients to South Africa for treatment. The ministries of health in South Sudan and Uganda signed an agreement enabling South Sudanese students to commence midwifery studies in Uganda.

C. Major national initiatives

34. Improving reproductive health must be a country-owned and country-driven process. To accelerate progress towards reducing maternal mortality and ending fistula, countries urgently need to allocate a greater proportion of their national budgets to health, especially reproductive health. Countries also require intensified, additional international technical and financial support. Progress has been made on integrating obstetric fistula into countries' national health policies and plans, including in Bangladesh, Burkina Faso, Ghana, Guinea, Guinea-Bissau, Mali, Madagascar, Mozambique, Sierra Leone, the Sudan and Uganda. In Afghanistan, the revised reproductive health policy and strategy focused on male involvement, emergency obstetric care, fistula and gender-based violence. In May 2012, the Government of Chad organized a conference to strengthen implementation of the national strategy for the fight against fistula, and to revitalize the National Task Force for Fistula.

35. To facilitate coordinated planning and interaction between partners working on all aspects of obstetric fistula, several countries have created a National Task Force for Fistula. These task forces are typically led by ministries of health, and comprise civil society organizations, medical providers and United Nations agencies. To date, 14 countries have developed national task forces for fistula, including Afghanistan, the Central African Republic, Mali and South Sudan. The Uganda task force serves as a role model, meeting regularly to enhance dialogue and coordination of fistula activities.

36. Countries around the world are reinforcing policies and strategies to better protect women and girls, and address multiple forms of gender-based violence, including human trafficking, sexual violence and exploitation, female genital mutilation/cutting and child marriage. The Government of the Niger has made gender equity, access to reproductive health, and zero tolerance of violence against women and girls constitutional rights. Most countries with high rates of child marriage, including Bangladesh, Burkina Faso, the Central African Republic, Eritrea, Ethiopia, India, Malawi, Mali, Mozambique, Nepal, Nicaragua and Uganda, have enacted legislation setting the minimum age of marriage at 18. Others are eliminating differences in the legal age between boys and girls. Enforcing such national laws is often challenging in rural and remote areas, however.

37. In 2011, UNFPA, jointly with United States Representative Carolyn Maloney and Campaign to End Fistula partners, organized a Congressional briefing in Washington, D.C., entitled "End fistula forever". The briefing aimed to educate members of Congress about fistula and to discuss the impact of United States support for fistula programmes globally.

IV. Actions taken by Member States and the United Nations and remaining gaps

A. Prevention strategies and interventions to achieve maternal health goals and eliminate obstetric fistula

38. Research shows that averting maternal death and disability, including fistula, is accomplished most effectively when universal access to three key interventions is ensured, namely, family planning, skilled birth attendance at every delivery, and access to emergency obstetric and newborn care.[15] To accelerate progress in maternal and newborn health and boost support to high maternal mortality countries, UNFPA launched the Maternal Health Thematic Fund and the Global Programme to Enhance Reproductive Health Commodity Security. The Maternal Health Thematic Fund supports the global Campaign to End Fistula and national fistula programmes in priority countries.

39. In regions with high maternal mortality and morbidity, the proportion of births attended by skilled health professionals has risen from 55 per cent in 1990 to 65 per cent in 2009, with vast disparities across regions and the lowest levels of skilled care in Africa and South Asia.[16] Midwives play a crucial role in preventing obstetric fistula by providing high-quality skilled delivery care, identifying when a woman's labour is prolonged or obstructed, through tools such as the partograph, and referring her to an obstetrician, gynaecologist or doctor when emergency obstetric care or Caesarean section is required. Midwives and doctors are vital to ensuring early management of new fistulas, as is referring women suffering from fistula to trained, expert fistula surgeons for care.

40. Several countries in Africa and Asia have taken steps to improve access to services by reducing or removing user fees for basic health care. Sierra Leone launched a major initiative in 2010 to provide free health care for pregnant women, lactating mothers and children under 5. Togo subsidizes 90 per cent of the cost of Caesarean sections since 2011. Bangladesh piloted a voucher scheme encouraging women to access antenatal and delivery services. Countries should ensure free or subsidized maternal health care for all poor women and girls who cannot afford it.

41. To intensify support to countries with some of the highest numbers of maternal and newborn deaths, in line with the Global Strategy for Women's and Children's Health, the "H4+" health agencies (UNAIDS, UNFPA, UNICEF, UN-Women, World Bank, WHO) launched the High Burden Country Initiative. The Initiative supports health system strengthening in Afghanistan, Bangladesh, the Democratic Republic of the Congo, Ethiopia, India, Mozambique, Nigeria and the United Republic of Tanzania, which account for nearly 60 per cent of global maternal and newborn deaths.

42. Access to services — particularly skilled birth attendance and emergency obstetric care — is the greatest challenge in preventing maternal mortality and

[15] For every 500,000 population and every subnational area or district, a minimum of five basic primary health facilities, with at least one of those facilities offering comprehensive emergency obstetric and newborn care.

[16] *Trends in Maternal Mortality: 1990 to 2010*; and *The State of the World's Midwifery 2011: Delivering Health, Saving Lives*.

morbidity.[17] Maternity waiting homes, low-cost or free accommodations located near or in a health facility, are a promising option to help bridge the geographical gap in access to care. They allow rural and "high risk" women to await delivery and, when labour begins, or earlier in case of complications, to be transferred to a medical facility nearby. They are also crucial to helping ensure access to elective Caesarean sections for fistula survivors who become pregnant again, to prevent fistula recurrence and increase the chances of survival of mother and baby. Although more evidence is needed, maternity waiting homes can have a positive impact on rural women's health and help to reduce maternal and newborn deaths and disabilities, as demonstrated in Cuba, Eritrea, Nicaragua and Zimbabwe.

43. Access to family planning helps to ensure that every pregnancy is wanted, planned and occurs at an optimal time in a woman's life. It is essential in reducing the risk of recurrence of fistula in future pregnancies of fistula survivors. UNFPA has advocated for building and maintaining political and financial commitment to family planning within maternal health strategies. In 2011, UNFPA supported the regional Conference on Population, Development and Family Planning in Francophone West Africa, held in Burkina Faso, and the International Conference on Family Planning in Senegal. The UNFPA Global Programme to Enhance Reproductive Health Commodity Security has mobilized $450 million since 2007 to ensure reliable supplies of contraceptives, condoms and medicines.

44. While preventing fistula from occurring is a top priority, it is essential not to forget treated fistula survivors who may be at risk of a further obstructed labour, and a new fistula, or even dying in subsequent pregnancies. This is an often overlooked, yet critical issue, on which the Campaign to End Fistula is placing new emphasis to ensure the survival of mother and baby and prevent recurrent fistula, through elective Caesarean sections for fistula survivors. This remains a neglected issue, however, and requires significantly intensified commitment and action.

45. Community sensitization and mobilization are key components of preventing obstetric fistula and maternal deaths. Fistula survivors can play a vital role as advocates in raising awareness about the need for timely antenatal, skilled delivery, and post-partum care.

46. The United Nations Inter-Agency Task Force on Adolescent Girls, in 2010, signed a joint statement to increase support to developing countries to advance key policies and programmes to empower the hardest-to-reach adolescent girls. To date, 20 countries have received support in planning comprehensive programmes addressing vulnerable girls.

B. Treatment strategies and interventions

47. Although prevention is the ultimate means of eliminating obstetric fistula, treatment is critically important for women living with the condition as it enables them to reclaim their lives, hopes and dignity. Countries have increased access to fistula treatment through upgrading health facilities and training health personnel. In 2011, significant progress was made to scale up treatment, and more than 7,000

[17] General Comment 14 of the Committee on Economic, Social and Cultural Rights defines accessibility as having four overlapping dimensions: non-discrimination, physical accessibility, economic accessibility and information accessibility.

fistula surgeries were directly supported by UNFPA, a 40 per cent increase from 2010. Hundreds of thousands of women and girls worldwide still await treatment, however, and global treatment capacities are severely deficient in reaching and healing them all. A tremendous backlog of patients continues to grow. A dramatic and sustainable scaling-up of quality treatment services and trained fistula surgeons is needed. Closing this gap is an important challenge currently facing countries and the Campaign to End Fistula.

48. Many poor women and girls cannot afford fistula treatment despite the fact that some countries now offer fistula treatment at no cost. Therefore, all countries should ensure access to free fistula treatment services. There is an urgent and ongoing need for committed national and donor support to provide the resources necessary to reach all women and girls suffering this condition. Increased multi-year commitments are critical to ensure sufficient, sustainable and continued programming.

49. Many women and girls living with fistula are not aware that treatment is available. For those who are, a major obstacle in accessing fistula repair services is the high cost of transportation to health facilities, particularly for those living in remote areas. In the Sudan, geographical accessibility was improved by locating fistula repair services close to remote communities. In 2011, the Aberdeen Women's Centre, Sierra Leone, set up a special toll-free hotline to provide information and care options for women with fistula, enabling over 220 patients to get treatment. Comprehensive Community-based Rehabilitation in the United Republic of Tanzania and the Freedom from Fistula Foundation in Kenya provide free fistula repair surgeries and developed a mobile telephone initiative to help those who cannot afford transportation costs. Using M-Pesa mobile-to-mobile banking technology, funds are transferred to fistula patients to cover transport costs. To facilitate access to fistula treatment services and improve quality of care, many countries, such as Angola and Yemen, are integrating fistula services into strategically selected hospitals, shifting away from the "mission or camp" approach for treating fistula. While intermittent missions or camps provide surgical repairs to high numbers of women, and are useful for training fistula surgeons, they have limited scope and potential. Moving forward from the mission/camp approach, countries should strive to establish integrated fistula services in strategically selected hospitals which are continuously available and provide the full continuum of holistic care and support for treatment, rehabilitation and crucial follow-up for fistula sufferers.

50. To improve the quality of care and ensure that all women receive the best treatment possible, the International Society of Obstetric Fistula Surgeons, promotes knowledge-sharing, professional development and quality assurance among fistula surgeons and health-care providers. The International Federation of Gynaecology and Obstetrics, with support from UNFPA and the International Society of Obstetric Fistula Surgeons, developed a competency-based training manual on obstetric fistula to harmonize surgical approaches and techniques among fistula centres. UNFPA is developing a supplementary document for Campaign to End Fistula partners and ministries of health that gives strategic recommendations on training fistula surgeons. Quality assurance remains a challenge. One primary concern is that many trained health providers in fistula management have limited support to practise their skills. Intensified efforts are needed to ensure that trained personnel have optimal working conditions, fully-equipped, functional health centres and incentives to

retain them to provide fistula repairs. Ensuring that providers respect pre-operative criteria, including patients' adequate nutritional status and fitness for surgery, to optimize surgical outcome, is also a challenge.

C. Reintegration strategies and interventions

51. Healing fistula requires not only surgical intervention but also a holistic approach, including psychosocial and economic support. Previously, very few countries reported on women who received reintegration on rehabilitation services, a key component of the continuum of care. In 2012, about 19 countries, including Afghanistan, Cameroon, Guinea-Bissau and Nepal, reported providing such services, reflecting increased commitment. However, follow-up of fistula patients is a major challenge. In most countries, only a fraction of fistula patients are offered reintegration services, despite significant needs. All fistula-affected countries should track this indicator to ensure access to reintegration services. Intensive social reintegration for inoperable or incurable fistula patients remains a major gap.

52. Reintegration services include counselling — throughout all phases of treatment and recovery, from the first point of contact, through post-discharge from hospital, reproductive health education, family planning, and income-generating activities, combined with community sensitization to reduce stigma and discrimination. In Pakistan, four fistula centres offer rehabilitation activities for fistula patients, including Koohi Goth Hospital in Karachi, started by a local doctor, Shershah Syed. Over 70 patients received rehabilitation support in 2011, with periodic follow-up to evaluate the impact.

53. Connecting fistula patients to income-generating activities provides a much needed livelihood, renewed social connections and sense of purpose. In the Congo, treated fistula patients are provided with a tutor to help create a business based on existing or desired skills. Patients are entitled to a bank account and training in business and financial literacy. Fistula Foundation Nigeria supports women with inoperable or incurable fistula with a training programme in various trades including embroidery, knitting and photography. In Ethiopia, a partner of the Campaign to End Fistula, Healing Hands of Joy, is implementing an innovative model of healing, empowerment and reintegration for fistula survivors, trained as "safe motherhood ambassadors". Despite these good practices, too few fistula survivors benefit from such vital socioeconomic reintegration services.

D. Data collection and analysis

54. Information on fistula-related activities is scarce, scattered, incomplete and difficult to obtain. Concerted efforts have been made to improve availability of data, including the launching of the first Global Fistula Map early in 2012. A standardized fistula module for inclusion in demographic and health surveys has been developed and used in Cameroon, Guinea and Guinea-Bissau. The Geneva Foundation for Medical Education and Research and WHO developed an online database that allows centralized data entry, analysis and comparison across programmes. Burkina Faso and Ghana have included fistula in their national health information systems. Development of a compendium of indicators is ongoing to assist countries in

selecting key indicators to monitor their fistula programming. Obtaining data remains a challenge, owing to inadequate data recording and reporting systems.

55. The Global Fistula Map will help to streamline the allocation of resources, raise awareness of fistula, and capture the landscape of worldwide fistula treatment capacity and gaps. Tragically, in the countries with the highest levels of maternal deaths and obstetric fistula, such as Burundi, Chad, the Central African Republic, Somalia and South Sudan, the map reveals the greatest gaps, with a severe lack of fistula treatment centres. It highlights the tremendous efforts made by many partners to treat fistula, and can be used as a tool to facilitate South-South collaboration. Data gathered shows that, while the availability of surgical treatment for fistula is growing, only a fraction of fistula patients receive treatment annually. More than half of reporting facilities treated fewer than 50 patients each in 2010. Only five facilities worldwide each reported treating over 500 women. The map will be expanded and continuously updated with information provided by experts and practitioners around the globe about fistula repair and rehabilitation services.

56. Maternal death and near miss[18] reviews are an increasingly recognized and utilized means to improve quality assurance. Maternal death surveillance and response was adopted by partners as a framework towards maternal mortality elimination as a global public health burden. Inter-agency consultations, as part of the Commission on Information and Accountability, have been organized in all regions, addressing needs for the institutionalization of maternal death reviews and maternal death surveillance and response. Benin, Burundi, Ethiopia, Ghana, Madagascar and Malawi are moving towards systematic maternal death audits to improve quality of care. In Bangladesh and Nepal, a national surveillance system is being initiated, with UNFPA support, to identify and treat "hidden" fistula cases.

57. In partnership with UNICEF, WHO and the Averting Maternal Death and Disabilities Programme of Columbia University, New York, UNFPA supported emergency obstetric and newborn care needs assessments in countries with high maternal mortality. The assessments map the current level of care and provide evidence needed for planning, advocacy and resource mobilization to scale up emergency services in every district. By 2011, about 24 countries had completed or initiated such assessments.

58. Far more research is needed to effectively address the problem of obstetric fistula. Johns Hopkins University, with UNFPA and WHO, is conducting a multi-centric study to examine the links between surgical prognosis and treatment and long-term health, psychosocial and reintegration outcomes following fistula surgery. This landmark study, launched in 2010, is ongoing in Bangladesh, Ethiopia and the Niger. Study results will help to develop a prognostic-based classification system for obstetric fistula, guide advocacy and inform cost-effective programmes and national strategies. Progress is slow, however, for lack of funds.

59. Finding ways of providing fistula repair services efficiently and cost-effectively, without comprising surgical outcomes and the overall health of the patient, is paramount. The Special Programme of Research, Development and Research Training in Human Reproduction of UNDP, UNFPA, WHO and the World

[18] A near miss is commonly understood as a severe life-threatening obstetric complication necessitating an urgent medical intervention in order to prevent the likely death of the mother (WHO, *Beyond the Numbers*, 2004).

Bank, jointly with EngenderHealth, is conducting a facility-based multi-centre randomized controlled trial in some African countries to examine whether short-term (7-day) catheterization following surgical repair of "simple" fistula cases is inferior to longer-term (14-day) catheterization in terms of fistula repair breakdown.

60. As midwives are the "front-line workers" in the fight to prevent obstetric fistula and maternal mortality, a skilled midwifery workforce is vital. Data on midwifery in the hardest-hit countries is, however, lacking. To fill the data gap, the Midwifery Programme launched by UNFPA and the International Confederation of Midwives, in 2011 issued the first *State of the World's Midwifery* report. This joint effort involved 30 global partners to generate data on midwifery workforce services and policies from 58 low-resource countries representing 91 per cent of the global burden of maternal mortality and 82 per cent of newborn mortality. Twenty-seven needs assessments and gap analyses were conducted and subsequent country action plans developed to strengthen midwifery policies and capacities.

E. Advocacy and awareness-raising

61. National champions and global activists support the Campaign to End Fistula. The First Lady of Sierra Leone, Mrs. Sia Nyama Koroma, fistula survivor Sarah Omega from Kenya, Natalie Imbruglia and Christy Turlington Burns are among many advocates worldwide who continue mobilizing support. Policymakers, national and local religious and community leaders and health professionals have a critical role in advocating for the rights of women and girls, and challenging harmful practices and gender inequities that threaten their well-being.

62. The Campaign to End Fistula was one of a few initiatives featured in *MDG Good Practices*, a publication by the United Nations Development Group which highlighted the innovative, comprehensive programmatic and advocacy approach of the Campaign. This approach has the potential to be significantly magnified at the global level to further strengthen advocacy and awareness-raising for ending obstetric fistula and will require intensified mobilization of human and financial resources.

63. Globally and nationally, there has been a stronger focus on coordinated advocacy and communication efforts to end obstetric fistula. However, developing the most high-impact, cost-effective and culturally appropriate means to convey health messages remains a challenge in many countries. Human rights concepts are key. Using the media, including social media, for awareness-raising and advocacy, utilizing radio, television and the press to send important messages on fistula prevention, treatment and social reintegration to effectively reach families and communities would narrow this gap.

64. Community-based communication and mobilization help to overcome barriers to obstetric fistula prevention and identify solutions that are culturally acceptable. One of the most innovative and successful approaches has been involving fistula survivors in community mobilization. There is no more powerful voice for promoting prevention and safe delivery, and helping "invisible" fistula survivors to access treatment, than a woman who has survived fistula. Eighteen countries have supported fistula survivors to sensitize communities, provide peer support and advocate improved maternal health at both community and national levels.

65. In 2011, for the first time in the history of the Campaign to End Fistula, fistula survivors participated in the annual meeting of technical experts of the International Obstetric Fistula Working Group, bringing a vital, yet previously missing, link to the table. This was not only a symbol of the international recognition of their valuable advocacy work with "One by one let's end fistula" in Kenya, but, more importantly, a key contribution to programmatic and strategic efforts at the global level. As a result of continued efforts by the Campaign's secretariat, many organizations are now working with fistula survivors and advocates to reach women and girls living with fistula, advocate for prevention, women's empowerment, men's engagement and political commitment to end fistula. In Bangladesh and the Niger, mobile telephones were provided to fistula advocates to improve coordination efforts and elicit greater involvement with communities in their villages.

F. Global support and resource mobilization

66. The Every Woman Every Child initiative aims to put the Global Strategy for Women's and Children's Health into action. By February 2012, about 217 commitments had been made. Some countries made important commitments, including free Caesarean section in subsequent pregnancies of fistula survivors, establishment of treatment centres and free fistula services. More than 25 business organizations have made commitments to the Strategy, including the first grant from Johnson & Johnson to a joint United Nations programme in Ethiopia and the United Republic of Tanzania.

67. A major challenge facing countries is the insufficiency of national financial resources for maternal health and obstetric fistula. This problem is compounded further by low levels of official development assistance directed for Millennium Development Goal 5. Contributions to the Campaign to End Fistula are vastly insufficient to meet the needs globally, and have steadily declined in recent years, in part because of the ongoing global financial crisis. Thus, urgent redoubling of efforts is required to intensify resource mobilization to ensure that fistula does not once again become a neglected issue.

68. Other initiatives that support maternal health and fistula prevention to accelerate the achievement of the Millennium Development Goals include the G-8 Muskoka Initiative on Maternal, Newborn and Child Health, the Partnership for Maternal, Newborn & Child Health, and the Health Eight.

V. Conclusion and recommendations

69. **Obstetric fistula is an outcome of socioeconomic and gender inequalities and the failure of health systems to provide accessible, equitable, high-quality maternal health care, including family planning, skilled attendance during childbirth and emergency obstetric care in case of complications. Over the past two years, considerable progress has been made in focusing attention on maternal deaths and disabilities, including obstetric fistula. Despite these positive developments, many serious challenges remain. It is a grave injustice that around the world, in the twenty-first century, the poorest, most vulnerable women and girls suffer needlessly from a devastating condition that has been virtually eliminated in the industrialized world.**

70. **Significantly intensified political commitment and financial mobilization are urgently needed to accelerate progress towards eliminating this global scourge and closing the gap in the unmet need for fistula treatment. Special attention should be paid and support intensified to countries with the highest maternal mortality and morbidity rates, especially those struggling to make sufficient progress towards Millennium Development Goal 5, for example, Burundi, Cameroon, the Central African Republic, Chad, the Congo, Guinea-Bissau, Lesotho, Sierra Leone, Somalia, South Sudan and Zimbabwe.**

71. **There is global consensus on the key interventions necessary to reduce maternal deaths and disabilities. Countries are increasingly investing in and promoting prevention, treatment and reintegration services for women living with obstetric fistula as part of holistic efforts to achieve Millennium Development Goal 5. There is, however, an urgent need to scale up the three well-known, cost-effective interventions, emphasizing the crucial role of midwives to reduce the high number of avoidable maternal deaths and disabilities.**

72. **Better understanding of the social and economic burden resulting from poor reproductive and maternal health has led to multi-sector approaches to address linkages between poverty, inequities, gender disparities, discrimination, poor education and health. Efforts to improve women's health should systematically include educating women and girls, economic empowerment, including access to microcredit and microfinance, and legal reforms and social initiatives to increase the age of marriage and delay early pregnancy.**

73. **Specific, critical actions, within a human rights-based approach that must be urgently taken by Member States and the international community to end obstetric fistula include:**

(a) **Greater investment in strengthening health systems, ensuring adequately trained and skilled human resources, especially midwives, obstetricians, gynaecologists and doctors, as well as investments in infrastructure, referral mechanisms, equipment and supply chains, to improve maternal health services and ensure that women and girls have access to the full continuum of care;**

(b) **Equitable access and coverage, through national plans, policies and programmes that make maternal health services, particularly family planning, skilled birth attendance and emergency obstetric and newborn care and obstetric fistula treatment geographically and financially accessible. Countries should ensure access, particularly in rural and remote areas, through the establishment and distribution of health-care facilities and trained medical personnel, collaboration with the transport sector for affordable transport options, and promotion and support of community-based solutions;**

(c) **Integration of fistula prevention and treatment and socioeconomic reintegration into national plans, policies, strategies and budgets, and systematic follow-up of fistula patients. States should ensure comprehensive multidisciplinary national action plans and strategies for eliminating fistula with emphasis on prevention. Emphasis must be placed on primary prevention at the levels of the law, policy and programmes. Women's and children's well-being and survival must be protected, including preventing recurrence of**

subsequent fistulas by making post-surgery follow-up and tracking of fistula patients a routine and key component of all fistula programmes;

(d) Increased national budgets for health, ensuring adequate funds allocated to reproductive health, including for obstetric fistula. Within countries, policy and programmatic approaches to redress inequities and reach poor, vulnerable women and girls must be incorporated into all sectors of national budgets. Countries should provide free or adequately subsidized maternal health care as well as obstetric fistula treatment for all women and girls in need who cannot afford it;

(e) Enhanced international cooperation, including intensified technical and financial support, in particular to high-burden countries, to accelerate progress towards Millennium Development Goal 5 and fistula elimination;

(f) Establishment or strengthening of a National Task Force for Fistula, led by the Ministry of Health, to enhance national coordination and improve partner collaboration;

(g) Ensuring access to fistula treatment through increased availability of trained, expert fistula surgeons as well as permanent, holistic fistula services integrated into strategically selected hospitals. This should be accompanied by quality control, and improved monitoring mechanisms to ensure that only trained, expert fistula surgeons provide treatment to address the significant backlog of women awaiting care;

(h) Developing a community- and facility-based mechanism for systematic notification of obstetric fistula cases to ministries of health, in a national register;

(i) Ensuring that all women who have undergone fistula treatment have access to social reintegration services, including counselling, education, skills development and income-generating activities. Countries should provide holistic services including intensive social reintegration support for the forgotten women and girls with incurable or inoperable fistula. Linkages with civil society organizations and women's empowerment programmes should be developed to help to achieve this goal;

(j) Empowering women who are survivors of obstetric fistula to contribute to community sensitization and mobilization as advocates for fistula elimination and safe motherhood;

(k) Mobilizing communities, and women in particular, to be involved, informed and empowered regarding reproductive health services and maternal health needs, utilization of services and support to women to access such services. Promoting the enhanced engagement of civil society and local religious and community leaders in raising awareness and reducing stigma, discrimination, violence against women and girls and harmful practices such as child marriage. Ensuring the involvement of men and boys as key stakeholders in advocating for and supporting women's access to reproductive health care and rights, gender equity, ending violence against women and girls, and preventing child marriage, recognizing that the well-being of women and girls has a significant positive effect on the survival and health of children, families and societies;

(l) Strengthening awareness-raising and advocacy, including through the media, to effectively reach families and communities with key messages on fistula prevention, treatment and social reintegration;

(m) Strengthened and expanded interventions to keep girls in school, especially post-primary and beyond, end child marriage, and protect and promote gender equality and the empowerment of women and girls. Laws prohibiting child marriage must be adopted and enforced, and followed by innovative incentives for families to avoid marrying girls off at early ages, including in rural and remote communities;

(n) Strengthening research, data collection, monitoring and evaluation to guide planning and implementation of maternal health programmes including obstetric fistula. Countries should conduct up-to-date needs assessments on emergency obstetric and newborn care and for fistula, and routine reviews of maternal deaths and near miss cases, as part of a national maternal death surveillance and response system, integrated within their national health information system.

74. **As the Campaign to End Fistula approaches its tenth anniversary, the challenge of putting an end to obstetric fistula requires vastly intensified efforts at the national, regional and international levels. Such efforts must be part of the strengthening of health systems, gender and socioeconomic equality and human rights, aimed at achieving Millennium Development Goal 5. If Goal 5 is to be achieved, additional resources must be forthcoming to accelerate progress. Funding must be increased, predictable and sustained. Significantly increased support should be urgently provided to countries' national plans, United Nations entities, including the Maternal Health Thematic Fund, the Campaign to End Fistula, and other global initiatives dedicated to achieving Millennium Development Goals 3 and 5 by 2015.**